Guidance and Exemplars for the Missouri First Steps IFSP Quality Indicators Rating Scale

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Missouri First Steps
IFSP Quality Indicators Rating Scale

This guidance document was developed through stakeholder workgroup with facilitation by the National Early Childhood Technical Assistance Center and reviewed by national experts in the area of early intervention.

Its purpose is to exemplify the components of a high-quality IFSP as noted by Missouri's IFSP Quality Indicators Rating Scale. Areas are rated on a Likert scale, with "1" representing Unacceptable, "3" representing Acceptable, and "5" representing Recommended Practice. In some cases, the stakeholder workgroup that developed the rating scale determined no "5" existed for an area – "3" what was acceptable and compliant with the IDEA, was in fact also recommended practice. In these instances, the "5" description is left blank.

This document is organized as follows: Each page has two-sides and is meant to be placed in a 3-ring binder for use in landscape format. The "top" (or back) of page shows a section of a sample IFSP. The "bottom" (or front of the next) page shows the IFSP Quality Indicators Rating Scale for that section, followed by Commentary explaining why the sample demonstrates best practice and Guidance discussing suggestions or tips on how IFSP teams can demonstrate similar high quality in devising IFSPs.

Some pages of the IFSP have multiple components rated. In these cases, the page is repeated for each rating scale. Areas of the page that are not pertinent to the rating scale below are shaded so the reader can focus on the unshaded part being discussed.

When Commentary or Guidance exceeds the available space on a single page, it continues to the next side. As a result, some "bottom" (or front) pages are left blank intentionally, to pick up the organization after these instances.

*Service Coordinator in this document refers to any type of service coordinator (intake, ongoing, family, DMH, etc.).

Thank you to the many contributors to this document

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Missouri DESE gratefully acknowledges the State of Virginia for its willingness to allow adaptation of its material

While the rating scale is developed for use directly with the IFSP alone, the DESE determined that it would be most helpful to provide a brief summary of information about the child used for this set of exemplars. This summary reflects Kim's current status, as well as provides some background as to the conversations that occurred to arrive at the identified outcomes.

****This section is neither desired nor required for IFSP development****

Kim Doe, who is currently 17 months of age, was referred to First Steps by David Johnson, MD, her pediatrician, in March 2003 due to failure to thrive associated with cardiac anomalies, encephalitis, microcephaly, spasticity and seizures. Kim is followed by neurology and cardiology in addition to her pediatrician. Dr. Johnson and his medical staff have been working with Kim's family regarding her nutritional needs to ensure sufficient weight gain and eventual removal of Kim's NG tube. She is currently on NG tube feeding only at night. Kim's most recent EEG showed no seizure activity; therefore, Kim is currently being weaned off her seizure medications.

Kim has been receiving supports and services through First Steps for the past year. Sally Jones, OTR, has been the primary service provider. Kim has been drinking between 10-15 ounces of Pediasure per day by bottle. She is able to drink about one ounce of liquid from a spouted cup when it is held for her. She accepts a variety of foods (different tastes, different textures) by spoon and she is able to move the food around in her mouth with her tongue. Has good lip closure. Kim takes between 5-10 spoonfuls of food per meal (mostly baby food) when seated in her adapted high chair. She does not eat the same foods that her family eats during mealtime. She is starting to make munching motions. She is swallowing liquids of varying consistencies, as well as soft foods, without choking. When new textures or foods are introduced she chokes/gags initially. It is not clear if her gagging and choking is due to oral hypersensitivity as a result of her NG tube or due to neurological concerns. She can hold a spoon and wave it when it is placed in her hand; she is not yet controlling the spoon to scoop food or bring food to her mouth or to finger feed. Kim has continued to gain weight, though Mrs. Doe reports that Dr. Johnson wants Kim to gain more weight before she can come off the night feeding tube.

Kim is not able to assist with dressing due to significant challenges in moving her arms and legs. She attempts to move her arms and legs when dressing but due to stiffness (spasticity) is unable to control her movements. She enjoys bath time.

Kim plays by reaching for and batting toys, touching pictures and making sounds, and watching and making sounds in response to what is happening around her. Mrs. Doe described the sound as a "gutteral sound in the back of her throat". She attempts to engage in imitative sound play by making throaty sounds following sounds made by others. She does not babble or make consonant sounds, which the team believes is most likely due to her NG tube since she appears to have good movement of her lips and tongue. She sometimes uses gestures and sounds to let her mom and dad know when she wants to be picked up, when she is full or doesn't like a particular food and sometimes to make choices about which book she wants to have read to her. She cries and fusses when she is not understood (and this happens several times every day).

Kim is able to support her head well when in her adapted seat, when she is held either in sitting or standing supported at her trunk, and when on her tummy or side. She is able to balance momentarily when propped in the sitting position (hands on the floor or on her knees), but is not able to regain her balance or get herself into the sitting position. She lifts her head and uses her abdominals to help get to sitting when her mom assists her by providing light assistance behind her shoulder as she guides her up toward one side. Kim is able to roll by herself from her stomach to her back and with some difficulty, but by herself, she also rolls from her back to her stomach. She moves short distances forward, sideways and backwards lying on her stomach mostly by twisting her body to inch along, though she is trying to use her hands and she does push against the floor with her legs. She is motivated to move in order to get her toys although she can't move very far.

Kim enjoys being with adults and other children including the children at the Rainbow Babies Playgroup in Anywhere City, Missouri. She watches the other children, laughs, and attempts to imitate sounds they make. Kim enjoys sound play with older children and adults. She shows a preference for toys that make sounds (by moving to, looking at and/or smiling when the toy is presented to her), especially ones that play tunes. She shows recognition of toys and objects by looking at them when they are named.

Kim is reaching with both hands and is able to move objects by swiping at them. She pats pictures and bangs toys. She is able to grasp toys and other objects that are placed in her hand, but she is not able to consistently open her hand to pick up an object by herself. She does not bring toys or hands to her mouth. Has spasticity/stiffness in both arms which impacts controlled arm/hand/finger movement for fine motor skills.

Conversations about the family's concerns, priorities, and resources revolved around helping Kim continue to increase her functional skills including sitting to play, eating meals with her family, sleeping through the night, and moving around by herself.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
The Individualized Family Service Plan describes
how the First Steps early intervention system will assist each family in helping
their very young child with a disability or developmental delay to grow and develop.

Section 1: CHILD INFORMATION

*Child's Name: *Kim Doe* *Nickname: *N/A* *Gender: M **F** A

*Home Street/Address: *555 Green Street* *Mailing Address: *same*

*City/Town: *Anywhere City* MO, Zip: *99999* *County: *Somewhere*

*Date of Birth: *12/08/02* Chronological Age: *17 months* Adjusted Age: N/A

*Reason for Eligibility: *Medical Condition* *Native Language : *English*

*School District: *Anywhere* *SSN#: *111-55-2222* *Medicaid #: *N/A*

DIRECTIONS TO CHILD'S HOME

Starting from I-64 and I-270 follow Magnolia Street to Jefferson Street (CVS and Shell station on corner). Turn right onto Jefferson Street. Go approximately 1 mile and turn right onto Green Street. Go 3 blocks – house is on the right (brick with grey door and trim). Address is on the mailbox.

***MEETING DATE INFORMATION:**

IFSP Meeting Type:

☐ Interim ☐ Initial ☐ 6 Month Review ☐ Interperiodic Review ☒ Annual ☐ Transition

Meeting Date: *5* / *12* / *04*

IFSP Start Date: *5* / *12* / *04* IFSP End Date: *5* / *11* / *05*

Child's Name: *Kim Doe* **Date:** *5-12-04*

Section 2: FAMILY INFORMATION

*Primary Contact: *Jane Doe*

*Relationship to child: *mother*

*Mailing Address: *555 Green Street*

*City/Town: *Anywhere City* *State: *MO* *Zip: *99999*

*Home/Street Address: *same*

*Day Phone: *555-1111* (h_x_ w___)
*Evening Phone: *same* (h___ w___)
*Best time to call: *M, W, F AM or late afternoon*
E-mail: *jane.doe@yahoo.com*
Other way to contact: *N/A*
*Native language: *English*
*Interpreter Needed? Yes No *X*

OTHER CONTACT INFORMATION:
*Name: *John Doe*

*Relationship to child: *father*

*Mailing Address: *same as above*

*City/Town: *same* *State: *same* *Zip: *same*
*Home/Street Address: *same*
*Day Phone: *555-2323* (h___ w_X_)
*Evening Phone: *555-1111* (h_x__ w___)
*Best time to call: *anytime*
E-mail: *john.doe@hotmail.com*

Section 3. SERVICE COORDINATOR CONTACT INFORMATION

*Name: *Barbara Black*

*Agency: *Somewhere SPOE*

*Work Telephone: *588-3232*

*Cell Phone: *512-3838*

*Best time to call: *8:30 AM to 4:00PM*

*FAX: *555-9999*

*E-mail address: *bblack@anywhereitp.org*

Mailing Address: *212 Magnolia Circle,*

City/Town: *Anywhere City*

*State: *Missouri* *Zip: *99998*

*MC+/Plan Contact Person : *N/A*

*Telephone: *N/A* *FAX Number: *N/A*

*Physician: *David Johnson, MD (pediatrician)*

*Address: *8923 Empire Boulevard*

*City/Town: *Anywhere City*, State: *MO* Zip: *99995*

*Telephone: *555-6234* * FAX: *555-8929*

E-mail: *david.johnson@westernpediatrics.org*

Guidance:

During an IFSP review, the most current information must be documented in this section of the IFSP (see Guidance for Ongoing Service Coordination)

Make sure all fields are completed and if not applicable designated by N/A. All portions of the IFSP should be legible.

As a reminder, the intake/ongoing service coordinator is responsible for ensuring that the IFSP is completed, however, other team members can assist as a recorder.

All intake forms and progress notes/case notes/log notes and IFSP planning documents should be used to collect and reflect information that will be used to develop the IFSP.

Child's Name: Kim Doe **Date:** 5/12/04

Section 4: CHILD'S PRESENT ABILITIES AND STRENGTHS: TEAM SUMMARY.

WHAT MY CHILD CAN DO NOW - INTERESTS, MOTIVATORS, NEW SKILLS, THINGS TO CELEBRATE, WHAT MY CHILD IS READY TO DO, WHAT'S WORKING WELL. Make sure that all developmental domains are included. Describe in an integrated, functional manner how this child: does things for him/herself (Adaptive/Self Help Skills); how s/he problem solves and plays (Cognition); how s/he uses hands, oral motor skills, how s/he moves around (Physical Skills); how s/he indicates understanding, wants, and needs (Communication Skills); and how s/he shows feelings, copes with frustration or stimulation, and gets along with others (Social/Emotional Skills).

Adaptive Self Help: At 17 months of age, what's working well for Kim is: drinks between 10-15 ounces of pediasure per day by bottle; drinks about one ounce of liquid from a spouted cup when it is held for her; accepts a variety of foods(different tastes/some textures) by spoon when fed; holds a spoon when placed in her hand and waves it and bangs; is able to move food around in her mouth with her tongue and is starting to make munching motions; takes between 5-10 spoonfuls of food per meal when seated in her adaptive seat; swallows soft foods and some liquids without problems; Some challenges for Kim include: chokes/gags initially when new textures and liquids are introduced; does not scoop food or bring spoon to mouth; no finger feeding; someone has to assist her when drinking from a cup; not able to assist with dressing or bathing. Mom states that meal times have become easier for Kim and her family over the past several months since she is sitting at the table and eating some baby foods. Kim's family is looking forward to when Kim's NG tube is removed and she is able to eat table foods and self-feed.

Cognition: What's working well for Kim includes: she watches people and is very interested in what is happening around her; looks for toys when dropped or rolled from view; Plays peek-a-boo; looks at people when named; likes toys that makes sound; shows recognition of toys and objects by looking at them when named. It is difficult to determine Kim's level of understanding due to motor challenges and inability to communicate thoughts, wants and needs.

Physical: What's working well for Kim includes: plays by reaching for and batting toys, patting pictures and banging toys; reaches with both hands and moves toys when batting at them; holds toys when placed in her hand and sometimes opens her hand and picks up toys; holds her head up when held in sitting or standing position and when on her tummy or her side; sits momentarily when propped in sitting position with hands on the floor or her knees; is able to get into sitting position with minimal help when laying on her tummy or back; easily rolls from her tummy to her back ; is able to roll from her back to tummy with more effort ; moves forward, backwards, and sideways short distances when on her tummy attempting to get from one place to another and to get toys; spends time in her adaptive seat and stander. Kim is challenged by her limited movement to be able to explore her environment and, play with her sister. Her motor skills also impact her purposeful play with toys and her ability to participate in independent feeding and/or dressing.

Communication: What's working well for Kim includes: makes throaty sounds and gestures to let her mom and dad know when she wants to be picked up, when she is full or doesn't like a particular food; sometimes makes sounds and gestures to indicate what book she wants read to her; enjoys sounds play with adults and children and does attempt to imitate sounds; she likes toys that make sounds, especially ones that play tunes. Kim's challenges include her inability to babble and make consonant and other sounds as a result of her NG tube. These challenges impact her ability to communicate her wants, thoughts, and needs with her parents, sister, grandparents and playgroup teacher.

Social/Emotional: What's working for Kim includes: enjoys being with most adults, especially her mom and dad and grandparents, and other children including the children at the playgroup where she attends 2 mornings a week; watches other children; frequently laughs and smiles at others; likes riding in the car and spending time and playing with her grandparents (reading books, playing games); cries and fusses when she is not understood and this happens several times a day; Kim's challenge is that her NG tube affects her sleep at night and leaves Kim fussy throughout the day. Kim and her sister do not take naps or go to bed at the same time which impacts Kim's mom ability to do chores.

Vision/Hearing: Her pediatrician checks her hearing and vision at each well-baby check – there are no concerns at this time. Her next appointment is at 18 months.
Health/Physical/Nutrition Status: Kim is on an NG tube at night because she continues to need to gain more weight. Kim currently weighs 15 pounds. She is being weaned off her seizure medications since a recent EEG shows no seizure activity. She is followed by cardiology and neurology as well as by her pediatrician. At well-baby checkups she sees the nutritionist.
Other Strengths/Concerns including relevant information (medical diagnosis, birth history, health status, sensory issues, etc.) or other concerns, which might affect service delivery. Kim was initially referred to First Steps due to failure to thrive associated with cardiac anomalies, encephalitis, microcephaly, spasticity and seizures.

Child Present Abilities and Strengths (Missouri IFSP Section 4)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Child's status (including strengths and needs) is described for each required developmental area (physical development including vision, hearing and health status, cognitive development, communication development, social or emotional development and adaptive development) in the context of everyday routines and activities.	The child's current status is summarized in terms of **one or more of the following:** • test scores • child's deficits • vague child strengths without describing developmental status as it relates to everyday routines and activities; or • all developmental areas are not included	The child's current status in each required developmental area is described functionally, including strengths and needs.	The child's current status in each required developmental area is described functionally, including strengths and needs relevant to challenges and what is working well in everyday routines and activities.
B. Child's interests, motivators fears and dislikes are related to participation in everyday routines.	The status of current abilities **does not** include information about people, places and things that are motivators, interests, fears and dislikes.	The status of current abilities includes a description of: • people, places, and things that *motivate, engage, and bring enjoyment to the child,* **and** • child's fears, concerns, and dislikes.	The status of current abilities includes sufficient information on people, places, and things that interest and motivate the child to participate in everyday routines and activities. **AND** There is information on how the child's concerns, fears or dislikes impact successful participation.

Commentary: What makes this section of the IFSP reflective of recommended practice?

- All developmental domains were covered
- Strengths and challenges are functionally stated
- Motivators are identified, including: wants to play with sister, interacts with other children at play group, enjoys being around children and adults
- Important people, places, things are identified, including: Grandparents, other children in playgroup where she goes 2 times per week, sister, playgroup teacher
- Challenges that impact participation in everyday routines: NG tube affects communication and interactive play; Gags with new textures and liquids impacts her ability to eat table foods with family; NG tube affects her sleep at night; Limited motor skills impacts her ability to engage in interactive play with her sister and other children
- Likes are identified: likes toys that make sounds; riding in the car; imitative play; and one-on-one interaction including reading books and playing games
- Dislikes are identified: textures and new foods/liquids, cries and fusses when she is not understood

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

It is important to know from the family's perspective what's working well or what is challenging in their everyday routines and activities. Conversations should collect the kinds of information that is on "Identifying Typical Family Routines and Activities" form and other relevant tools for identifying family routines and activities, family interests, etc. In completing these conversations, active and reflective listening should be used. Open ended questions such as: "tell me about _____." . . . "How are things going?" . . . "What's the best thing that's been happening in last several months?" . . . "What do you like to do together as a family?" . . . .

Conversations with families that identify child strengths and needs in everyday routines and activities begin at the initial contact and continue through intake and IFSP development and review. Recognizing the family's challenges can help guide the initial evaluation and the ongoing assessments, focusing more on areas that are challenging for the family. All developmental domains must be assessed.

"Other Strengths/Concerns" must be completed when there is relevant information to IFSP planning. If there are no other influencing factors for the individual child record, N/A (not applicable) must be recorded in this Section.

While the "Identifying Typical Family Routines and Activities" form is optional, its use will facilitate high quality completion of this section.

Child's Name: Kim Doe **Date**: 5/12/04

Section 5. SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES TO ENHANCE THE DEVELOPMENT OF THEIR CHILD

Family declined consent to complete an assessment of family concerns, priorities and resources: ☐ Yes X No (If "yes" leave this section blank, If "no" this section must be completed.)

I have questions about or want help for my child in the following areas:

- X Moving around (crawling, scooting, rolling, walking)
- X Ability to maintain positions for play
- X Talking and listening
- ☐ Thinking, learning, playing with toys
- X Feeding, eating, nutrition
- ☐ Having fun with other children; getting along
- ☐ Behaviors and feelings
- X Toileting; getting dressed; bedtime; other daily routines
- ☐ Helping my child calm down, quiet down
- ☐ Pain or discomfort
- ☐ Special health care needs
- ☐ Seeing or hearing
- ☐ Other: _____

I would like to share the following concerns and priorities for myself, other family members, or my child:

- ☐ Finding or working with doctors or other specialists
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Parenting skills
- X People who can help me at home or care for my child so I/we can have a break; respite or child care
- ☐ Housing, clothing, jobs, food, or telephone
- X Information on my child's special needs, and what it means
- X Ideas for brothers, sisters, friends, extended family
- ☐ Money for extra costs of my child's special needs
- ☐ Linking with a parent network to meet other families or share information
- ☐ Other: _____

FAMILY'S CONCERNS ABOUT THEIR CHILD:

- Kim gags and chokes when new foods/liquids are introduced and Kim's mom has to spend a good amount of time working to help Kim overcome her dislikes of new foods and textures – Kim's mom is concerned about how long it will take to transition Kim to table food that the rest of the family eats
- Kim and her sister are not on the same sleep schedule (going to bed, awaking in the morning or napping during the day) so Kim's mom doesn't always finish all of her chores and is frequently tired as Kim does not yet sleep through the night
- Several times a day, Kim cries and fusses because Kim's parents and sister do not always understand what she wants or needs
- Kim attempts to initiate play with her sister but is unable to move very far around the living room on her own and is unable to tell her sister what she wants to play with
- Grandmother doesn't like to feed Kim because she gags/chokes on new foods.
- She is fed every 3-4 hours during the day and is on a feeding tube at night. She wakes several times during the night taking 10-15 minutes to get back to sleep.

PRIORITIES OF THE FAMILY (Select from items checked to the left)

- Would like Kim to sleep through the night and get both Kim and her sister on the same sleep routine so Kim's mom feels rested and better able to do daily chores
- Would like Kim to be able to gain enough weight to be off the night tube feeding and for Kim to be able to eat table foods with the rest of the family at meal times
- Would like Kim to be able to let people know what she wants.

STRENGTHS, RESOURCES THAT OUR FAMILY HAS TO MEET OUR CHILD'S NEEDS:

- Kim usually spends her day at home with her mom and sister but she has recently started attending a playgroup two mornings a week. This time at playgroup is an opportunity for Kim to be with other children and for Kim's mom to do daily chores.
- Kim's maternal grandparents spend time with Kim and her family almost every Sunday after the family returns from church. Her grandparents are very helpful with Kim and her parents
- Transporting Kim to the playgroup, the store, church, etc. is easy.
- She spends about 30 minutes 2x/day playing on the living room floor with her sister.

Summary of Family Concerns, Priorities and Resources (Missouri IFSP Section 5)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. With the concurrence of the family, information is included on the people who are important to the child and family and the family's concerns and resources. This information is connected to the family's everyday routines and activities.	The IFSP contains ***no*** information on family concerns, priorities, or resources, **AND** there is **no** documentation that the family **declined** to provide information on concerns, priorities and resources. **OR** The IFSP contains information about family routines and activities but *no specific* information on **all of the following:** important people concerns interests resources	With family concurrence, information is described on **all of the following**: family concerns family interests important people for the family other resources **BUT** this information **is not** connected to what is working well and the challenges in the family's everyday routines and activities. **OR** The family declined to provide information and documentation is present.	With family concurrence, information is described on **all of the following**: family concerns family interests important people for the family other resources **AND** this information **is connected** to what is working well and the challenges in the family's everyday routines and activities.
B. With family concurrence, there is clear information on family priorities and how they link to family concerns, strengths and interests	There is **no** information provided about family priorities. **AND** There is no documentation that the **family declined** to share this information.	With family concurrence, family priorities are described. **OR** The family declined to provide information and documentation is present.	With family concurrence, information on family priorities is present along with how the priorities are linked to the family concerns, strengths and interests.

Commentary: What makes this section of the IFSP reflective of best practice?

- Concerns, interests, important people for the family and other resources have been identified and are connected to what is working well and the challenges as follows:
  - Interests: Family wants mealtime to be a family time and want grandparents to be actively involved
  - Important People and Places: Church and grandparents are important to Kim and her family and grandparents are supportive and involved
  - What's working: Grandparents are involved, Kim goes places with her family, Kim attends playgroup 2x/week
- Challenges are related to everyday routines: Kim is not eating table food with her family; Kim and her sister are not taking naps or going to bed at the same time which impact's mom's ability to complete chores

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

With the concurrence of the family, the Family Assessment is conducted by interview with the family prior to the IFSP meeting. The Service Coordinator uses the Summary of Family Concerns, Priorities and Resources section of the IFSP as an interview format, and with the family's concurrence, the summary will become part of the IFSP document. It is important for the Service Coordinator to help the family identify the supports and services necessary to enhance their capacity to meet the

developmental needs of their child. The information that is gathered will help guide the team's discussion and decisions about the family's priorities for outcomes for the child and family and about appropriate services to address these outcomes.

Prior to this interview, the Service Coordinator will have gathered a substantial amount of information from the family through the Social History interview, completion of the worksheets "Getting to Know Our Child" and "Identifying Typical Routines and Activities" and other informal conversations occurring in the process of planning for evaluations and assessments, etc. During these conversations and during the Family Assessment interview, the Service Coordinator should use active/reflective listening. S/he should use open-ended questions such as, "Tell me about _____," … "How are things going?" … "What is the best thing that has happened in the last several months?" …. "What do you like to do together as a family?" The information gathered during the intake process should serve as a good springboard for the Family Assessment interview. For instance, "When we talked earlier, you mentioned that going to church is very important to your family, but that you do not feel comfortable taking John because of his inappropriate behaviors. Would you like to include this as one of your concerns in this section of the IFSP?"

Once concerns have been identified, service coordinators and early intervention providers must assist the family in identifying those concerns that are most appropriate to be addressed at this time. These concerns are listed as priorities and these priorities subsequently lead to outcomes on the IFSP.

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Child's Name: Kim Doe **Date:** 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___1____:

Kim will eat with her family, eating the foods they eat.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Mrs. Doe will introduce one new food or liquid with a different taste/texture as Kim is able to eat or drink previously introduced foods/liquids without gagging and choking. If possible, the new food item should be a mashed item that the family eats regularly, such as potatoes, peas, and carrots. **(Occupational Therapist's services will help parent identify and sequence foods to achieve this.)**
- Mrs. Doe will encourage Kim to help pick foods and drinks at the grocery store and help make choices at mealtime, or snack time at home, as incentives for Kim trying new tastes and textures of different foods and drinks.
- Kim will be given opportunities to watch other children eat at playgroup and when possible at church gatherings, McDonalds or other restaurants that the Doe's frequent and will be reinforced with praise whenever she tries foods/liquids that other children are eating and drinking.
- At each mealtime, Mrs. Doe will give Kim 3 different foods/textures. **(Occupational Therapist will help identify sequence of foods to introduce.)**
- Information about high calorie foods will be shared with Kim's parents. **(Provided through dietician/pediatrician.)**
- Family will work with Kim to increase her grip. **(OT services will help address this directly and in direct consultation to the family.)**
- Adaptations to feeding utensils/bowls/cups and seating adaptations may be used to determine what might help improve Kim's self-feeding skills and calorie intake. **(Occupational Therapist's services will help address this strategy.)**
- Pediatrician will determine the rate of weight gain Kim needs to maintain, in order to reduce and then stop night tube feedings. Mrs. Doe will weigh Kim daily and report this information to the pediatrician and her service coordinator.

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress towards the outcome will be measured by:

- Parents will share with the team any Increase in Kim's intake of new foods or liquids, increase in ability to eat foods with the family (when she eats one meal every day and then begins eating two meals some days), decrease in the need for night time tube feeding while maintaining desired weight gain until physician recommends that tube feeding is no longer necessary.

Our team will be satisfied we are finished with this Outcome when: (criteria)

- When Kim is able to eat 2 meals every day with her family, eating food from the table and gaining/maintaining sufficient weight for removal of the night tube feeding.

Family and Child Centered Outcomes (Missouri IFSP Section 6)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Child and family outcomes correlate with family priorities and concerns relative to the child's development.	Child and family outcomes seem to be based on provider priorities (e.g., there is not a clear connection with the concerns and priorities expressed by the family). **AND/OR** **No** family outcomes are included related to specific family needs and concerns as expressed in MO IFSP (see Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child).	Child and family (when identified by team) outcomes are clearly based on family concerns and priorities (e.g. there are clear connections between information in MO IFSP Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child and Section 6: Family and Child Centered Outcomes).	
B. Child outcomes are functional, measurable (including criteria, procedures, and timelines) and related to participation in everyday routines.	Child outcomes are written: • as services to be provided, **and/or** • in discipline-specific therapeutic language, **and/or** • in vague terms, rather than written as functional and measurable.	Child outcomes are: • functional, **and** • measurable (including criteria, procedures, and timelines).	Child outcomes are **all of the following**: • functional • measurable (including criteria, procedures, and timelines) • related to participation in everyday routines and activities.
C. Child outcomes are developmentally appropriate and can realistically be achieved in the given review period.	Child outcomes: • have little or no relationship to the information on the child's current functioning, **and/or** • are not likely to be achieved given the review period.	Child outcomes: • are consistent and relevant with information on child's current functioning, **and** • can realistically be achieved in the agreed upon review period.	

Commentary: What makes this section of the IFSP reflective of best practice?

- The outcome clearly relates to family concerns and priorities because the family mentioned in Section 5 Concerns, Priorities & Resources wanting Kim to eat table foods with rest of family and to be off the night tube. The outcome ties to the family's concern with Kim's weight gain and also with mom's concern with being tired because the decrease of night tube will mean more sleep and time for mom.
- The outcome is functional because eating is a necessary part of the daily routine.
- It is measurable given the information about 2 meals a day, eating the same foods as the family, and the idea of monitoring the decrease/removal of night tube.
- The outcome is related to participation in every day routines because they are working on Kim eating with the family which is an important daily family routine.
- The outcome is relevant to functioning since Kim is beginning to eat baby food and issues are more related to texture than safety.
- The outcome can realistically be achieved because Kim is already moving towards these goals. She is showing pre-readiness skills for the outcome.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

When family states desired outcomes that are unrealistic (developmentally out-of-sync, appropriate for children of different age or prior skill-set), it is essential that the service coordinator ask questions to guide the family to set realistic outcomes for a six to 12 month review period. The family should be able to have big goals, but

the IFSP team must help the family develop some realistic outcomes for the next six to 12 months. "What would you like to see your child doing in the next six to 12 months?" (related to everyday routines, related to big goals)
Initial conversations with the service coordinator could talk about the family's big goals and brainstorm realistic outcomes prior to the IFSP meeting to prepare the family for the IFSP meeting.

Look back at Section 5 Concerns, Priorities & Resources to find daily challenges. Help the family identify those things that are most important right now given the family priorities listed in that section. It is not necessary to have every need or concern addressed immediately because that may be overwhelming to the family.
Recognize the big goals that families may have from Section 5 and then talk about realistic outcomes.
When the family says something broad and you need to narrow it down, questions that might help include, "Tell me more about that." Or "Tell me more about what that means to you."

To help you get to the criteria, search for detail. "Describe what that would look like." "How often is she doing ____ now? Where could we be in six to 12 months?"
In some instances families may not understand developmental stages. The provider may want to share developmental milestones with the family. When the family wants to set an unrealistic outcome, the provider might share: "Before we get to _____, we need to do _____. So we need to work on early steps that will progress towards that goal."

Sometimes, families might suggest outcomes that are appropriate as intermediate steps. If families presents outcomes that will most likely be achieved sooner than 6 months, then the team should have a conversation about reaching something beyond that period of time. Discuss with the family that if the child obtains these outcomes sooner than 6 months, then an IFSP team meeting will be held to develop new outcomes.

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Child's Name: Kim Doe **Date:** 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___1____:

Kim will eat with her family, eating the foods they eat.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Mrs. Doe will introduce one new food or liquid with a different taste/texture as Kim is able to eat or drink previously introduced foods/liquids without gagging and choking. If possible, the new food item should be a mashed item that the family eats regularly, such as potatoes, peas, and carrots. **(Occupational Therapist services will help parent identify and sequence foods to achieve this.)**
- Mrs. Doe will encourage Kim to help pick foods and drinks at the grocery store and help make choices at mealtime, or snack time at home, as incentives for Kim trying new tastes and textures of different foods and drinks.
- Kim will be given opportunities to watch other children eat at playgroup and when possible at church gatherings, McDonalds or other restaurants that the Doe's frequent and will be reinforced with praise whenever she tries foods/liquids that other children are eating and drinking.
- At each mealtime, Mrs. Doe will give Kim 3 different foods/textures. **(Occupational Therapist will help identify sequence of foods to introduce.)**
- Information about high calorie foods will be shared with Kim's parents. **(Provided through dietician/pediatrician.)**
- Family will work with Kim to increase her grip. **(OT services will help address this directly and in direct consultation to the family.)**
- Adaptations to feeding utensils/bowls/cups and seating adaptations may be used to determine what might help improve Kim's self-feeding skills and calorie intake. **(Occupational Therapist's services will help address this strategy.)**
- Pediatrician will determine the rate of weight gain Kim needs to maintain, in order to reduce and then stop night tube feedings. Mrs. Doe will weigh Kim daily and report this information to the pediatrician and her service coordinator.

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress towards the outcome will be measured by:

- Parents will share with the team any increase in Kim's intake of new foods or liquids, increase in ability to eat foods with the family (when she eats one meal every day and then begins eating two meals some days), decrease in the need for night time tube feeding while maintaining desired weight gain until physician recommends that tube feeding is no longer necessary.

Our team will be satisfied we are finished with this Outcome when: (criteria)

- When Kim is able to eat 2 meals every day with her family, eating food from the table and gaining/maintaining sufficient weight for removal of the night tube feeding.

Family and Child Centered Outcomes: Intervention Strategies and Activities (Missouri IFSP Section 6)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Early intervention strategies and activities support the child's and family's everyday routines and activities and build family capacity (confidence and abilities).	Strategies and activities reflect only what the professional will do with the child, and only include specialized places and equipment.	Strategies and activities reflect that the First Steps personnel are supporting the family/caregivers to implement intervention strategies, which take place in the home and community settings.	Strategies and activities reflect that the family and/or caregiver(s) implement strategies <u>in the context of everyday routines and activities of interest with professionals providing direct service and/or consultation and coaching for family/caregiver learning and problem-solving.</u>
B. Early Intervention strategies and activities are written in family-friendly language, are individualized to the family, address the child and family's specific needs and concerns, and build on child and family interests and strengths.	Strategies and activities: • are written in professional jargon, **and/or** • seem so general that they could appear on any IFSP.	Strategies and activities are: • written in commonly understood language, **and** • individualized to address the child and family's specific needs and concerns.	Strategies and activities are **<u>all of the following:</u>** • written in easy to understand language • individualized to the specific needs and concerns of the child and family • <u>related to child and family interests,</u> • <u>built on child and family strengths.</u>
C. Early Intervention strategies and activities are linked to the child's functional skills and are connected to the identified outcomes.	Strategies and activities are disjointed and not connected to the outcome (e.g., they could be implemented in isolation without achieving the outcome). **AND/OR** Strategies and activities do not link with the child's functional skills.	Strategies and activities are connected to the outcome and reflect the child's functional skills.	

Commentary: What makes this section of the IFSP reflective of best practice?

- Strategies are clear, specific, in simple words (not therapy sounding).
- They are very focused on natural routines as they include other environments (McDonalds, church).
- Strategies are written in clear, basic steps that families can understand and are very realistic for families since they build on existing family routines.
- Strategies are built on child and family strengths such as Kim being able to communicate to Mom about foods she does not like; they build on the fact that Kim enjoys the playgroup and watching other children.
- They reflect the child's functioning skills because Kim is already eating some foods, enjoys the playgroup, etc.
- Strategies seem to utilize many people and resources so that it's a real team effort.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

This section must be completed to achieve a high quality IFSP, even though listed as "optional" for compliance purposes.
Avoid the use of technical jargon. Try to use everyday language/terminology.

Include the team in a discussion about what kinds of strategies during daily family routines would lead to the outcome. Do not START with talking to therapists about what they can do to help the families. Only ask this AFTER the strategies are articulated to determine what providers are needed and what they will do specifically. While the discussion is a dynamic conversation, by starting the conversation with a question such as, "What strategies can the family / caregivers implement to achieve this outcome?" and following that discussion with, "Does the family / caregiver need assistance in implementing these strategies?," many individuals may be involved in accomplishing the strategy, and family capacity will increase.

It is important to review the child's abilities and family Concerns, Priorities and Resources listed previously. Relate the strategies to everyday activities that families do rather than what the therapist will do. "What can you (mom and dad) do to support this outcome?" "Who are other people in your child's life that can help with the strategies? How can we include those other people who are already involved in your child's daily routines?"

Remind the family that First Steps philosophy is family-focused and emphasizes building family capacity within the family's natural routines. As a result, strategies and activities are intended to help the family with everyday activities. You might explain how the First Steps model of enhancing family capacity is different than the medical model where they take their child somewhere to work with the therapist. "We're not expecting you to 'do therapy,' but in this model we're giving you some activities that you can work into things you're already doing everyday such as bath time, bed time, at meals, while dressing, play time." You could give the family a copy of the Medical Model vs. Routines Based model comparison that shows the child actually gets more using the Routines Based model.

Write strategies so that the parent can understand them and what their role is in the activities. When the strategies are written, ask the families if they feel the strategies are clear and realistic (as opposed to feeling overwhelmed).

Once all outcomes and strategies have been determined and the team identifies what assistance the family needs to implement the strategies and achieve the outcome, note the relationship of the service provider to the outcomes – this is shown in bold after the applicable strategies. In this way, providers can look at their authorization (in this instance, OT for 60 minutes 1x/mo) and know what the team expects the OT's focus to be during the time authorized. This also gives families an idea of what the provider will be doing when present.

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Child's Name: Kim Doe **Date**: 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___2____:

Kim will increase her ability to communicate what she wants and needs to people she comes in contact throughout her daily activities and routines.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Kim's mom will show Kim two different items of clothing each day while dressing and ask her to reach for or look at which one she wants to wear. Whichever item Kim reaches for or looks at first, Kim's mom will name and put on her.
- Kim's parents, grandparents and playgroup teacher will show Kim two different toys or books, and ask her to reach for or look at which one she wants to play with or read. Whichever item Kim reaches for or otherwise indicates as her choice will be named and then played with or read to her. **(Special Instructor will help address this)**
- Kim's parents, grandparents and playgroup teacher will give Kim a choice of two objects/activities in a variety of settings and Kim will make a choice.
- IFSP team members will provide coaching and support, as needed, on how to encourage choices in a variety of settings**. (Speech/Language Pathologist will consult with the Special Instructor so the Special Instructor can assist family)**

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress toward the outcome will be measured by successful or unsuccessful attainment of strategies and activities that lead toward the outcome. Parents will share with the team any increase in Kim's ability to communicate her wants, especially when Kim indicates what she wants once a week in multiple settings and three times per week in multiple settings.

Our team will be satisfied we are finished with this Outcome when: (criteria)

Kim is able to consistently communicate what she wants to wear, play with or do regardless of where she is while with her parents, grandparents, therapist or playgroup teacher. Parents will report greater success in matching Kim's gestures/sounds to her desires.

Family and Child Centered Outcomes (Missouri IFSP Section 6)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Child and family outcomes correlate with family priorities and concerns relative to the child's development.	Child and family outcomes seem to be based on provider priorities (e.g., there is not a clear connection with the concerns and priorities expressed by the family). **AND/OR** **No** family outcomes are included related to specific family needs and concerns as expressed in MO IFSP (see Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child).	Child and family outcomes are clearly based on family concerns and priorities (e.g. there are clear connections between information in MO IFSP Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child and Section 6: Family and Child Centered Outcomes).	
B. Child outcomes are functional, measurable (including criteria, procedures, and timelines) and related to participation in everyday routines.	Child outcomes are written: • as services to be provided, **and/or** • in discipline-specific therapeutic language, **and/or** • in vague terms, rather than written as functional and measurable.	Child outcomes are: • functional, **and** • measurable (including criteria, procedures, and timelines).	Child outcomes are **all of the following**: • functional • measurable (including criteria, procedures, and timelines) • related to participation in everyday routines and activities.
C. Child outcomes are developmentally appropriate and can realistically be achieved in the given review period.	Child outcomes: • have little or no relationship to the information on the child's current functioning, **and/or** • are not likely to be achieved given the review period.	Child outcomes: • are consistent and relevant with information on child's current functioning, **and** • can realistically be achieved in the agreed upon review period.	

Commentary: What makes this section of the IFSP reflective of best practice?

- The outcome is measurable
- The outcome is based on family concerns (Kim's ability to let people know what she wants). This helps Kim be more functional in her environment because she can communicate with others. It is consistent with current functioning and realistic because Kim is already communicating some at home. Emerging skills are there.
- The outcome is based on everyday routines because it's at home, at church, in restaurants, in play group.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

See pages 17-18.

Child's Name: Kim Doe **Date**: 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___2____:

Kim will increase her ability to communicate what she wants and needs to people she comes in contact throughout her daily activities and routines.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Kim's mom will show Kim two different items of clothing each day while dressing and ask her to reach for or look at which one she wants to wear. Whichever item Kim reaches for or looks at first, Kim's mom will name and put on her.
- Kim's parents, grandparents and playgroup teacher will show Kim two different toys or books, and ask her to reach for or look at which one she wants to play with or read. Whichever item Kim reaches for or otherwise indicates as her choice will be named and then played with or read to her**. (Special Instructor will help address this)**
- Kim's parents, grandparents and playgroup teacher will give Kim a choice of two objects/activities in a variety of settings and Kim will make a choice.
- IFSP team members will provide coaching and support, as needed, on how to encourage choices in a variety of settings. **(Speech/Language Pathologist will consult with the Special Instructor so the Special Instructor can assist family)**

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress toward the outcome will be measured by successful or unsuccessful attainment of strategies and activities that lead toward the outcome. Parents will share with the team any increase in Kim's ability to communicate her wants, especially when Kim indicates what she wants once a week in multiple settings and three times per week in multiple settings.

Our team will be satisfied we are finished with this Outcome when: (criteria)

When Kim is able to consistently communicate at least one time of day what she wants to wear, play with or do regardless of where she is while with her parents, grandparents, or playgroup teacher. Parents will report greater success in matching Kim's gestures/sounds to her desires.

Family and Child Centered Outcomes: Intervention Strategies and Activities (Missouri IFSP Section 6)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Early intervention strategies and activities support the child's and family's everyday routines and activities and build family capacity (confidence and abilities).	Strategies and activities reflect only what the professional will do with the child, and only include specialized places and equipment.	Strategies and activities reflect that the First Steps professionals are supporting the family/caregivers to implement intervention strategies, which take place in the home and community settings.	Strategies and activities reflect that the family and/or caregiver(s) implement strategies <u>in the context of everyday routines and activities of interest with professionals providing direct service and/or consultation and coaching for family/caregiver learning and problem-solving.</u>
B. Early Intervention strategies and activities are written in family-friendly language, are individualized to the family, address the child and family's specific needs and concerns, and build on child and family interests and strengths.	Strategies and activities: • are written in professional jargon, **and/or** • seem so general that they could appear on any IFSP.	Strategies and activities are: • written in commonly understood language, **and** • individualized to address the child and family's specific needs and concerns.	Strategies and activities are **<u>all of the following:</u>** • written in easy to understand language • individualized to the specific needs and concerns of the child and family • <u>related to child and family interests,</u> • <u>built on child and family strengths.</u>
C. Early Intervention strategies and activities are linked to the child's functional skills and are connected to the identified outcomes.	Strategies and activities are disjointed and not connected to the outcome (e.g., they could be implemented in isolation without achieving the outcome). **AND/OR** Strategies and activities do not link with the child's functional skills.	Strategies and activities are connected to the outcome and reflect the child's functional skills.	

Commentary: What makes this section of the IFSP reflective of best practice?

- Strategies are clear, specific, in simple words (not therapy sounding).
- They are very focused on natural routines as they include other environments (home, play group, any other community settings).
- The strategies include clear, basic steps that are understandable for the family; very realistic for family since it builds on existing family routines.
- Strategies are built on child and family strengths since Kim is already beginning to communicate so this extends that strength and Kim's parents and grandparents enjoy playing with her, so strategies build on existing activities and routines.
- The strategies incorporate the child's functioning skills because Kim is already making throaty sounds and looks at or gestures toward items.
- Strategies seem to utilize many people and resources so that it's a real team effort.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

See pages 20-21.

Child's Name: Kim Doe **Date:** 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___3____:

Kim will sleep through the night and take daytime naps and go to bed at the same time as her sister.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Pediatrician will determine the rate of weight gain Kim needs to maintain, in order to reduce and then stop night tube feedings. Mrs. Doe will weigh Kim daily and report this information to the pediatrician and her service coordinator.
- Information/resources on putting children to bed at the same time every day will be shared with Kim's parents. **(Service Coordinator will contact Parents As Teachers to assist Mom in enrolling.)**
- Kim's family will learn about and assist Kim's improvement in the developmental area of sleeping.
- Kim's parents will keep a schedule for one week of when they put Kim and her sister down for naps and at night to determine a time that might work best for both girls.
- Kim's parents will make every effort to consistently put Kim and her sister down for afternoon naps at the same time every day.
- Kim's parents will determine a bedtime routine (e.g. dinner, bath, reading, bed) to help the girls get used to a new routine. Once both girls are adjusted to the naptime routine, Kim's parents will make every effort to consistently put Kim and sister to bed at the same time at night.
- IFSP team will give additional suggestions to the parents as challenges arise. **(Service Coordinator will assist in coordinating this.)**

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress towards the outcome will be measured by:

- Parents will share with the team any decrease in the need for night time tube feeding while maintaining desired weight gain until physician recommends that tube feeding is no longer necessary.
- Parents will share with team any increase in frequency of Kim napping and going to bed at the same time as her sister, especially when this occurs almost every day.

Our team will be satisfied we are finished with this Outcome when: (criteria)

- When both girls successfully go down for a nap and go to bed at the same time and night tube feedings are reduced or eliminated.

Family and Child Centered Outcomes (Missouri IFSP Section 6)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Child and family outcomes correlate with family priorities and concerns relative to the child's development.	Child and family outcomes seem to be based on provider priorities (e.g., there is not a clear connection with the concerns and priorities expressed by the family). **AND/OR** **No** family outcomes are included related to specific family needs and concerns as expressed in MO IFSP (see Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child*).*	Child and family (when identified by team) outcomes are clearly based on family concerns and priorities (e.g. there are clear connections between information in MO IFSP Section 5: Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child and Section 6: Family and Child Centered Outcomes).	
B. Child outcomes are functional, measurable (including criteria, procedures, and timelines) and related to participation in everyday routines.	Child outcomes are written: • as services to be provided, **and/or** • in discipline-specific therapeutic language, **and/or** • in vague terms, rather than written as functional and measurable.	Child outcomes are: • functional, **and** • measurable (including criteria, procedures, and timelines).	Child outcomes are **all of the following**: • functional • measurable (including criteria, procedures, and timelines) • related to participation in everyday routines and activities.
C. Child outcomes are developmentally appropriate and can realistically be achieved in the given review period.	Child outcomes: • have little or no relationship to the information on the child's current functioning, **and/or** • are not likely to be achieved given the review period.	Child outcomes: • are consistent and relevant with information on child's current functioning, **and** • can realistically be achieved in the agreed upon review period.	

Commentary: What makes this section of the IFSP reflective of best practice?

- The outcome clearly relates to family concerns and priorities because the family mentioned in Section 5 Concerns, Priorities & Resources their concern with Kim's weight gain and also with mom's concern with being tired because the decrease of night tube will mean more sleep and time for mom.
- The outcome is functional because sleeping is a necessary part of the daily routine.
- It is measurable given the idea of monitoring the decrease/removal of night tube and the consistency of sleeping on a regular routine.
- The outcome is measurable because Mom can report if the kids are going to bed at the same time and report if she now has time to herself and to complete chores.
- The outcome is based on family concerns because Mom previously expressed a need for time to do chores and free time.
- The outcome is consistent with current functioning and realistic because Kim is already taking nap and sleeping some at night, this is extending that.
- The outcome is based on everyday routines because it's at home, she already naps and so does sister.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

See pages 17-18.

Child's Name: Kim Doe **Date:** 5/12/04

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # ___3____:

Kim will sleep through the night and take daytime naps and go to bed at the same time as her sister.

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services.)

- Pediatrician will determine the rate of weight gain Kim needs to maintain, in order to reduce and then stop night tube feedings. Mrs. Doe will weigh Kim daily and report this information to the pediatrician and her service coordinator.
- Information/resources on putting children to bed at the same time every day will be shared with Kim's parents. **(Service Coordinator will contact Parents As Teachers to assist Mom in enrolling.)**
- Kim's family will learn about and assist Kim's improvement in the developmental area of sleeping.
- Kim's parents will keep a schedule for one week of when they put Kim and her sister down for naps and at night to determine a time that might work best for both girls.
- Kim's parents will make every effort to consistently put Kim and her sister down for afternoon naps at the same time every day.
- Kim's parents will determine a bedtime routine (e.g. dinner, bath, reading, bed) to help the girls get used to a new routine. Once both girls are adjusted to the naptime routine, Kim's parents will make every effort to consistently put Kim and sister to bed at the same time at night.
- IFSP team will give additional suggestions to the parents as challenges arise. **(Service Coordinator will assist in coordinating this.)**

When will we as a team measure progress towards this outcome? (timeline)

Review strategies and activities for effectiveness at least monthly and outcome at least once every 3-6 months.

How will we, as a team, measure progress towards this Outcome? (procedure)

Progress towards the outcome will be measured by:

- Parents will share with the team any decrease in the need for night time tube feeding while maintaining desired weight gain until physician recommends that tube feeding is no longer necessary.
- Parents will share with team any increase in frequency of Kim napping and going to bed at the same time as her sister, especially when this occurs almost every day.

Our team will be satisfied we are finished with this Outcome when: (criteria)

- When both girls successfully go down for a nap and go to bed at the same time and night tube feedings are reduced or eliminated.

Commentary: What makes this section of the IFSP reflective of best practice?

- Strategies are clear, specific, in simple words (not therapy sounding).
- They are very focused on natural routines in the home where Kim and her sister takes naps.
- The outcome ties to the concern Mom has with Kim's fussy-ness and her own fatigue related to poor night sleeping due to the NG tube.
- Strategies are written in clear, basic steps that families can understand and are very realistic for families since they build on existing family routines.
- Strategies are built on child and family strengths such as Kim being able to communicate to Mom about foods she does not like; they build on the fact that Kim enjoys the playgroup and watching other children.
- They reflect the child's functioning skills because Kim is already napping and sleeping some at night, and these strategies extend those skills.
- Strategies seem to utilize supports found with families of typically-developing children (PAT), rather than retaining supports only in the early intervention community.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

See pages 20-21.

Child's Name: Kim Doe **Date:** 5/12/04

Section 7. *EARLY INTERVENTION RESOURCES, SUPPORTS AND SERVICES This entire page is part of electronic record.

Column A	Col. B	Column C	Column D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J	Col. K	Col. L
Outcome(s) #	Early Intervention Service(s)	Start Date	End Date	Provider(s) Name	Method (see below)	Ind. Or Group	Location (see below)	Frequency	Intensity	Funding Source	Initial (I) Addition (A) Revision (R)
# 1	Occupational Therapy	5/12/04	5/11/05	Sally Jones, OTR	3	Ind.	1	1x/mo	60 m	A	I
# 1 & 2	Special Instruction	5/12/04	5/11/05	Jane Smith, M.Ed.	3	Ind	1	2x/mo	1hr	A	I
	Special Instruction	5/12/04	5/11/05	Jane Smith, M.Ed.	3	Ind	3	2x/mo	1hr	A	I
	Special Instruction	5/12/04	5/11/05	Jane Smith, M.Ed.	1	Ind	3	1x/mo	30 m	A	I
# 2	Speech Pathologist	5/12/04	5/11/05	Chatty Cathy, SLP/CCC	1	Ind	3	1x/mo	30 m	A	I
# 1 - 3	Service Coordination	5/12/04	5/11/05	Barbara Black, SC	1	Ind	1	1x/mo	15 m	A	I

1) Column F, Method Code: 1 = Consultation/Facilitation with Others; 2 = Family Education/Training/Support; 3 = Direct Child Service
2) Column H, Location Code: 1 = Home; 2 = Other Family Location; 3 = Community Setting; 4 = Special Purpose Center or Clinic

Primary Setting for this IFSP: (circle) special purpose facility - community setting - home - hospital - residential facility - service provider location - other setting

Early Intervention Resources, Supports and Services (Missouri IFSP Section 7)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Frequency, intensity, and method of specific early intervention services relate to child and family outcomes and the family's/caregiver's capacity and need for support and problem solving of challenges.	Specific child and family services are not listed. **OR** Frequency, intensity, and method are not included for each specific service; **OR** Frequency, intensity, and method for each specific services is documented but information and/or number of service providers involved indicate that: • a clinical model of direct therapy will be implemented, **and/or** • family capacity will most likely not be enhanced, **and/or** • families are likely to feel overwhelmed or burdened.	Specific child and family services are listed and seem reasonable given: • the developmental status of the child • the family's concerns, priorities and resources • the IFSP outcomes; **AND** Frequency, intensity, and method are specified for each service and seem reasonable and fit into the family's daily routines and priorities given **all of the following**: • the developmental status of the child • the family's concerns, priorities and resources • the IFSP outcomes.	Specific child and family services are listed and seem reasonable given **all of the following:** • the developmental status of the child, • the family's concerns, priorities resources • the IFSP outcomes; **AND** Frequency, intensity, and method are specified for each service and seem reasonable and fit into the family's daily routines and priorities given **all of the following**: • the developmental status of the child • the family's concerns, priorities resources • the IFSP outcomes **AND** There is evidence in the strategies of building family capacity through consulting across disciplines (or environments where concerns are being addressed by a single provider) and coaching with the family.

Commentary: What makes this section of the IFSP reflective of best practice?

- Family capacity is being built through consultation across disciplines (SLP with Special Instructor) and coaching with the family.
- Frequency, intensity and method fit into family routines. The number of services and people fit into the family's routines and priorities without being too frequent or too many to be overwhelming. A variety of delivery and locations are used – home, at playgroup and through consultation between professionals, rather than having every provider coming in and out of the family's home. Services are reflective of family concerns and priorities. Services are appropriate for accomplishing the outcomes.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

Every service clearly relates to an outcome. The document clearly identifies who is responsible for each outcome. EVERY column is completed! Don't leave any blank.

Ensure services reflect the First Steps philosophy to support family and build family capacity. When finished completing this section, have the team reflect on the big picture and discuss the frequency and intensity and whether that builds the family capacity or is overwhelming.

Services that seem to require ongoing delivery (at least 6 months) cannot be authorized for more than one year. Other services may be determined to be time-limited and the team should discuss an appropriate end date. Make sure to clearly understand definitions of methods - **coaching the family or caregiver to help with certain activities is direct service provision.** If the IFSP team has determined the need for the provider to meet with the family or caregiver when the child is not present or it is not essential for the child to be present, this is consultation. For frequency, instead of 26x/yr, put 2x/mo in order to best reflect the expectation of the IFSP team for service delivery. To write 26x/yr would allow a provider to be in the home 26 times in a single month and then be "done" with services for the year, or request an additional authorization. Start dates are the date of the IFSP meeting because providers may begin services any time after that date. Later start dates may be specified as determined by the IFSP team.

Child's Name:_____ Date:_____

*Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Loan • Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Assistive Technology (Missouri IFSP Section 7a)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**

A. Assistive Technology services and supports are provided when needed to achieve identified outcomes and support the child's participation in family routines and community settings.
 	
RATE THIS AREA ONLY IF THE IFSP INCLUDES ASSISTIVE TECHNOLOGY
	Assistive Technology is not clearly related to the identified outcome.	Assistive Technology is clearly necessary to achieve IFSP outcomes based on **all of the following** information:
		• the child's developmental status
		• IFSP outcomes
		• strategies and activities
		.
			Assistive Technology:
			• is clearly necessary to achieve IFSP outcomes, **and**
			• enables the child to **participate** in everyday routines and activities based on **all of the following** information:
			  • the child's developmental status
			  • IFSP outcomes
			  • strategies and activities.

B. Assistive Technology devices are chosen with careful consideration of the child's needs and the appropriate method(s) to achieve the outcome. (skip this item if no AT is included in the IFSP) **RATE THIS AREA ONLY IF THE IFSP INCLUDES ASSISTIVE TECHNOLOGY**	Specialized Assistive Technology equipment is authorized even when there is no documentation that it is necessary in the IFSP; and typically available equipment/ materials could be used/adapted to meet the child's needs.	Specialized Assistive Technology equipment is included in the IFSP: • when necessary to meet outcomes, **and** • when typically available equipment/materials cannot be used / adapted to meet the child's needs.	

Commentary: What makes this section of the IFSP reflective of best practice?
While in this IFSP the OT is assisting with adaptive equipment for feeding, there is no evidence that the team needs to recommend the purchase of assistive technology, therefore, no authorization was included.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?
The IFSP team must decide that the child requires assistive technology to achieve one or more outcomes in the IFSP and that the AT will enable the child to participate in the strategies in the IFSP and therefore better participate in daily routines. Appropriate AT will enable a child to do what he/she otherwise would not be able to do.

The team should explore low cost alternatives. What other low tech devices have been tried (e.g. using a picture board vs. an electronic device; toy ball from Wal Mart vs. therapy balls)? Low tech devices often utilize naturally occurring family resources (for instance, a picture board can be developed and adapted regardless of caregiver knowledge, but an electronic device might require additional training for family members to interact with the child). Purchasing therapy equipment and toys to place in a child's home is not appropriate. Use the toys and other objects in the child's home. Items you might purchase for a typically-developing child (swing sets, trampolines) are not appropriate AT, nor are home modifications, car modifications, or ball pits.

Will the child have time to use this device during his/her participation in First Steps (prior to age 3)? While a device may transfer to the public school at age 3 or the family may be allowed to keep a device that is customized for their child and won't be likely to be useable for another child, it is not intended that First Steps purchase AT devices with that long term use and adaptability in mind.

In any case, once decisions about assistive technology are made based on the child's need related to the IFSP outcomes, they are described on the IFSP in general terms and not be specific brand (e.g., "switch-activated device with voice output" rather than "Big MAK").

Decisions about how and where to procure AT are left to the SPOEs and Service Coordinators. Decisions related to the specific model or brand are made by the SPOE, and the SPOE researches the best option for obtaining the device (searching their own loaner bank, checking for available items from other SPOEs loaner banks, purchasing from a variety of providers). The SPOE then prepares the authorization.

Service coordinators should maintain awareness of community resources available to the child (Missouri AT project, Telephone Pioneers, Capable Kids, Cappers, Easter Seals, March of Dimes, MD Association, Shriners, Love Fund, Children's Miracle Network, Dream Factory, lending libraries). All team members need to have knowledge and access to information about policies and best practice around AT. The service coordinator should ensure other funding sources have been explored for buying the AT. Very often items can be made significantly less costly by a local community resource (e.g. 4H Club) than a place that has specialized equipment.

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Child's Name:_____ Date:_____

*Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Loan • Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Transportation (Missouri IFSP Section 7b)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Transportation services relate to outcome(s) and are necessary to enable the eligible child and the child's family to receive early intervention services.	Transportation services are necessary for achieving the outcome but are not included in the IFSP. **OR** Transportation services are included in the IFSP, are not necessary for achieving the outcome, and appear to be just a convenience for the provider and/or family.	Transportation services are included in the IFSP and are necessary for achieving the outcome(s) and a justification explains why a service is not in the child's natural environment **OR** All services are provided in natural environments and no transportation is necessary or included in the IFSP.	.

Commentary: What makes this section of the IFSP reflective of best practice?
In this case, no services are provided away from the child's natural environment and typically-occurring routines, so transportation is not required.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

This section ties closely to Section 8, Natural Environments Justification.

Transportation authorizations are quality when the justification of services provided outside the natural environment is acceptable and transportation services included are related to the justified provision of services outside the natural environment.

Transportation authorization correlates to the specified services and the plan for transitioning these services to the natural environment. Transportation authorizations are not provided to/from services that are provided in community settings associated with the family's typical routines and activities (i.e., child care, park, YMCA, McDonalds').

Child's Name:_____ **Date**:_____

Section 8: Natural Environments Justification

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Natural Environments Justification (Missouri IFSP Section 8)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. Adequate information and evidence is provided to support the rationale that a child's needs and outcomes cannot be achieved in natural settings.	The IFSP identifies one or more services that are not in a natural environment for the child and family **AND** There is no justification or the justification is not based on the needs of the child but appears to be for: • administrative convenience, **and/or** • fiscal reasons, **and/or** • personnel limitations, **and/or** • parent/therapist preferences	The child is receiving **most** services in natural environments **AND** When a service is provided in a setting that is not a natural environment, a justification is included in the IFSP that is based on the needs of the child, justifying that the setting is necessary to achieve the outcome.	**All** services are provided in natural environments. **OR** The child is receiving **most** services in natural environments **AND** When a service is provided in a setting that is not a natural environment, a justification is included in the IFSP that is based on the needs of the child, justifying that the setting is necessary to achieve the outcome. **AND** For each service justified there is a plan to transition interventions into natural settings.

Commentary: What makes this section of the IFSP reflective of best practice?

All services are provided in the child's natural environment of home or playgroup.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

Administrative convenience, fiscal reasons, personnel limitations, and parent or therapist preferences are NOT acceptable justifications for providing services outside the natural environment. The following are additional examples of unacceptable statements.

Administrative convenience – e.g., convenience for First Steps personnel, such as equipment rooms.

Fiscal reasons - e.g., agency refusal to transport portable equipment due to liability, vehicle space availability, travel costs or need for additional personnel to transport/operate equipment in natural environment.

Personnel limitations - e.g., provider availability (whether due to scheduling or number of enrolled providers in the area), decisions about necessary services determined based on provider availability (use of special instructor instead of OT due to no enrolled OTs in area) for services or evaluations.

Parent preferences - e.g., comfort with providers in the home, desire for "time off" or ability to be away from child during services, desire for an individual provider from previous experiences even though other providers exist who will come to the natural environment, parent belief that services outside the natural environment will enable the family to receive other benefits (SSI-eligibility, more or greater amount of services, "better" equipment), parent belief in clinic-based services.

Therapist preferences - e.g., a perceived "undesirable" family address or area, refusal to travel away from the clinic or to a particular area or distance, a belief in clinic-based services or a belief in the effectiveness of a particular service methodology or implementation style (hippotherapy, discrete trial training, aquatherapy, therapy room, music therapy, etc.)

Services outside the natural environment may be justified when necessary specialized equipment is unable be transported to the child or found in the natural environment or a community setting within the natural family routines, or family lives in a shelter and shelter rules prohibit services being provided, etc.

In these cases, justification would indicate why such specialized equipment or methodology is necessary for the child (testing or training of peripheral vision or auditory equipment or that the use of such equipment or methodology is a temporary means to increase the child's skills), **and** how such equipment or services are necessary to achieve a particular outcome within the family's typical routines. Identification of a particular disabling condition cannot be cited as suitable justification.

Plan to transition interventions into natural settings: Justification should incorporate a plan to transition interventions into natural settings. Such plan might include references to the limited duration of service authorization and explanation of how service outside the natural environment is a precursor step in implementing specific strategies to achieve a particular outcome. Plan includes how the transition will occur, whether through another IFSP meeting, automatically with end of service authorization, etc. This plan will be listed on the Transition Checklist under "Other Transition."

Child's Name:_____Kim Doe_____ **Date**:_____*5/12/04*_____

Section 9: * Other Services **This entire section is part of the electronic record.**

Service	Family or Child Service	Responsible Individual	Fund Source
Neurology	child	Dr. C.A. Brain	Private insurance
Cardiology	child	Dr. I.M. Heart	Private insurance
Playgroup	Family & child	Merry Go Round Playgroup	parent
P.A.T.	Family & Child	Somewhere School District	School District
	family / child		

No Rating Scale exists for this section, and thus no Commentary or Guidance is provided.

Child's Name: _____ **Date:** _____

Section 10: Transition Checklist

Transition Activities into, within and from First Steps: Identification of activities and responsible individuals to assist the family and child with transitions include:	Specific Transition Issue	Who is responsible
Transition into and within: (Optional)		
1. Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services		
2. Family related changes that may affect IFSP service delivery i.e., employment, birth or adoption of sibling, medical needs of other family members)		
3. Child related changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)		
4. Introduction of new or a change in: Service Provider (s) Service location (s)		
5. Termination of existing IFSP service		
6. Explore community program options for our: Child Family		
7. Child and Family exiting First Steps system due to Loss of eligibility Family does not consent to participate		
8. Other Transition	Over the next several months the team, including Mr. and Mrs. Doe will discuss when it is appropriate for Sally's OT services to be reduced to possibly once every 2 months with consultation to Jane as Special Instructor and schedule an IFSP meeting as appropriate.	
Comments:		
Transition from (age 2.5 years): 9 & 10 required at each IFSP Meeting		
9. **Discussion** with, and training of parents regarding future placements and other matters related to the child's transition	Anywhere School District Point of Contact is Sally Ranch at 555-9999; ECSE eligibility will require evaluation, which will occur between 2.5 and 3 yrs of age. Transition meeting will occur around May 2005 because school is not in session at 2.5 exactly. Other options include Head Start, Home Schooling or Preschool programs such as ABC Preschool & Wee Learning Center.	Barbara/Service Coordinator & Jane Doe/Parent.
10. **Discussion** about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting	As Kim gets closer to participating in school-based services, team will discuss the frequency of participation in her playgroup and whether Kim shows difficulty separating from her service	Barbara/Service Coordinator Jane Doe/Parent, Jane Smith/SI & Sally

	providers in order to facilitate that transition.	Jones/OTR
11. **Send** with parental consent, information about the child to the local education agency to ensure continuity of services including evaluation and assessment of information and IFSPs		
12. **Send** specified information to community programs, upon informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system		
Comments		

Transition (Missouri IFSP Section 10)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. The IFSP includes documentation that transition issues are identified and discussed and steps are included to prepare the family for choices/ options at different transition points.	**No** information is noted in the IFSP, even about the required age three (3) transition items on the Transition Checklist.	The required transition discussion items in the Transition Checklist and transition issue(s) specific to the child and/or family needs and interests are identified (as appropriate) in the IFSP. **and** The steps that support the transition to either Part B Preschool services or other services that may be available as appropriate to the child are also described including **all of the following:** • specific places • programs • dates • people who will need to be involved in the transition process.	

Commentary: What makes this section of the IFSP reflective of best practice?

Item 9 on the Transition Checklist discusses timelines and points of contact for transition to ECSE, as well as other specific options in the community should the family choose to withdraw Kim from First Steps services or not participate in or be eligible for ECSE services. People who need to be involved in the transition process are listed as the school point-of-contact and under "Who is responsible."

Item 10 discusses Kim's current participation in group settings with her non-disabled peers and anticipates possible transition-related needs with regard to separating from family or service providers. All team members charged with observing these areas are specified.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

The section on "Transition Into and Within" should be completed when the IFSP team thinks one or more of the transition items listed are possible or likely to occur prior to the next meeting. Instances might include scenarios where the family moves often, guardians change frequently (i.e., foster care), family members change occupations or work schedules (such as on-demand or seasonal work), family has changed providers between meeting dates previously, sibling development or healthcare needs, custody arrangements, military or family-care arrangements, or provider availability issues (maternity, moving, etc.).

Transition out of First Steps must be addressed at each IFSP meeting. Item 9 speaks specifically to the preparation and training of parents regarding transition, while Item 10 identifies needs for preparing the child for changes in services between Parts C and B of the Individuals with Disabilities Education Act.

Key points for Item 9 may include exiting as a result of achieving age-appropriate developmental levels, parent's ability to withdraw their child from services, preparation for the differences in eligibility and format between Part C and ECSE services (including differences between the IFSP and IEP, and changes in frequency, intensity and type of services provided in early childhood settings that reflect a focus on school-readiness), the name and structure (points of contact, department or section) of the school district, transition activities that will occur (evaluation, transition meeting, timelines, summer birthdays, etc.). Dates identified may include "no later than" dates for Service Coordinators to refer family to the school district.

Key points for Item 10 may include preparing the child to be in group settings or in different frequency, intensity and type/location of services, touring school facilities, meeting school staff, assisting the child in "saying goodbye" to First Steps service providers ("graduation," "party," goodbye cards), etc.

It is not anticipated that preparation for school-based services will lead to an increase in group therapy services. However, it would be likely that children in First Steps, along with their non-disabled peers, would begin to participate in community-based activities such as larger playgroups and preschool/childcare settings. As these natural changes in the family's typical routines occur, it is appropriate for services to transition from being entirely provided in the home to being split between the home and community setting. The IFSP team/Service Coordinator may need to assist the family in identifying community options for their child to participate with non-disabled peers in the community.

Child's Name: Kim Doe **Date**: 5/12/04

Section 11: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation
Barbara Black	Service Coordinator	Somewhere SPOE	588-3232	*Barbara Black*
Jane Smith, M.Ed.	Special Instructor	Children First	555-8345	*Jane Smith*
Sally Jones, OTR	Occupational Therapist	Jones Rehab Center	555-6123	*Sally Jones*
Jane Doe	Parent			*Jane Doe*
Chatty Cathy, SLP/CCC	Speech Therapist	Language Inc.	555-9999	*Chatty Cathy*

How will this team keep in touch? How often?

Barbara, as service coordinator, will communicate monthly with Mrs. Doe by phone and touch base with Jane Smith, Chatty Cathy, and Sally Jones via monthly conference calls. Barbara will contact all IFSP team members no later than 10-15-04 to schedule 6 month review meeting.

Guidance:

"How will this team keep in touch?" includes who, how and when communication will occur for and between all team members and addresses next review period (including, as desired, the exact date for the next IFSP meeting). It describes the expected method and frequency of communication between the Service Coordinator and family.

Child's Name:_____ Current IFSP Date:_____ Revision Date:_____

Section 12: IFSP Review Documentation Worksheet

☐ 6 Month Review ☐ Interperiodic Review

Team Evaluation Scales: 1= Situation changed: outcome not needed, 2= Situation unchanged; still need outcome, 3= Outcome partially attained, 4 = Outcome accomplished

Outcome #	Progress Summary	Team Evaluation	Modifications/Revisions

IFSP Review (Missouri IFSP Section 12)			
Review area	**1 (unacceptable)**	**3 (acceptable)**	**5 (best practice)**
A. **SIX MONTH & ANNUAL REVIEW:** Child/family response to strategies and progress toward achieving child and family outcomes is documented and necessary changes are made in the IFSP.	There is inadequate information on how well strategies are working for child/family and if child and family outcomes are being achieved. **OR** Information provided is focused on provider activities (e.g., what's being done to the child). **AND/OR** Changes in IFSP are not justified by progress or there are not changes that appear necessary based on progress.	For **all outcomes**, information describes how well strategies are working toward achieving outcomes. **AND** For **child outcomes**, there is information on: • progress toward meeting the outcomes, **and** • current developmental status including child behavior and skills. **AND** Information is adequate for reviewers to determine if modifications and revisions are appropriate.	For **all outcomes**, information describes how well strategies are working toward achieving outcomes. **AND** For **child outcomes**, there is information on **all of the following**: • progress toward meeting the outcomes • current developmental status including child behavior and skills • discussion of child behavior and skills in everyday routines and activities. **AND** Information is adequate for reviewers to determine if modifications and revisions are appropriate.
B. **INTERPERIODIC REVIEW:** Child/family response to strategies and progress toward achieving child and family outcomes is documented and necessary changes are made in the IFSP.	There is inadequate information on how well strategies are working for child/family and if child and family outcomes are being achieved. **OR** Information provided is focused on provider activities (e.g., what's being done to the child). **AND/OR** Changes in IFSP are not justified by progress or there are not changes that appear necessary based on progress.	For **specified outcomes**, information describes how well strategies are working toward achieving outcomes. **AND** For **child outcome(s)**, there is information on: • progress toward meeting the outcome(s), **and** • current developmental status including child behavior and skills. **AND** Information is adequate for reviewers to determine if modifications and revisions are appropriate.	For **specified outcomes**, information describes how well strategies are working toward achieving outcomes. **AND** For **child outcome(s)**, there is information on **all of the following**: • progress toward meeting the outcome(s), • current developmental status including child behavior and skills • discussion of child behavior and skills in everyday routines and activities. **AND** Information is adequate for reviewers to determine if modifications and revisions are appropriate.

Commentary: What makes this section of the IFSP reflective of best practice?
This section was not completed as part of this set of exemplars.

Guidance: What steps need to be taken to ensure that this section of the IFSP is of high quality?

SIX MONTH REVIEW: This section addresses each outcome and the progress made toward meeting the outcome, rather than being focused **only** on what has not yet been achieved. This section addresses child's progress in order to determine the need for continuation of services or changes to services, rather than family or provider preferences or changes in family or home situation. This section continues to reflect a focus on increasing the family's capacity within the family's typical routines and natural environment.

Discussion of child's current development, including behavior and skills in everyday routines and activities indicate increases (or decreases) in family capacity or

improvement (or lack of) in the child's functional skills across the family's everyday routines and activities. The Modifications/Revisions section indicates changes or revisions made in light of team evaluation and this discussion. Examples may include situations where an outcome is achieved and the team determines a reduced need for services or development of a new outcome, or where the situation is unchanged and outcome is still needed but will be addressed in a different manner.

With regard to the adequacy of information for reviewers to determine appropriateness of modifications and revisions, "reviewers" refers both to the IFSP team making the determinations during the Six Month and Annual Review and the individual(s) using the IFSP Quality Indicators Rating Scale. The IFSP team needs adequate information to determine appropriateness of any changes, and the IFSP document itself needs to be reflective of such information, both as historical record of progress toward meeting outcomes and as documentation of high quality.

In instances where the Six Month and Annual Review is conducted without a face-to-face team meeting (e.g., through conference call, or some members participate by report or polling IFSP team members for 6 month reviews), all of the above components must still be achieved. It is anticipated that developing IFSP consensus across family, provider(s) and service coordinator will be complex without interactive participation.

INTERPERIODIC REVIEW: This section is identical to the Six Month Review section, except that all outcomes reviewed are addressed, rather than addressing every outcome in the IFSP.